Liberty General Insurance Ltd.
15th Floor, Unit-1501&1502, Tower 2,
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Senapati Bapat Marg,
Prabhadevi, Mumbai- 400013
IRDAI Reg. No.150, CIN: U66000MH2010PLC269656

HealthPrime Connect

A. POLICY SCHEDULE

The Policy Schedule is enclosed with the Policy document shared with you comprising the benefits and Sum Insured/Limits applicable to every available cover.

B. PREAMBLE

Liberty General Insurance Limited (hereinafter called the "Company", "Insurer" , **"We, Our, or Us"**) will provide insurance cover to the person(s) (hereinafter called the "Insured" , **"You, Your, or Yourself"**) based on the Proposal and Declaration made and agreed premium paid within such time, as may be prescribed under the provisions of the Insurance Act, 1938, for the Policy Period stated in the Schedule or during any further period for which the Company may accept payment for the renewal or extension of this Policy, subject always to the terms, conditions, provisos, exclusions, and limitations contained herein or endorsed or otherwise expressed herein. This Policy records the agreement between the Company (We) and the Insured (You), and sets out the terms of insurance and obligations of each party.

C. DEFINITIONS

The words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

i. Standard Definitions (Definitions whose wordings are specified by IRDAI)

1. **"Accident"** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **"Any one illness"** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital/nursing home where treatment was taken.

3. **"AYUSH Hospital":** An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. **"AYUSH Day Care Centre":** AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **"Cashless facility"** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured person in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization approved.

6. **"Condition Precedent"** means a policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

7. "**Congenital Anomaly**" refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a) "Internal Congenital Anomaly" means which is not in the visible and accessible parts of the body.
   b) "External Congenital Anomaly" means which is in the visible and accessible parts of the body.

8. "**Cumulative Bonus"** Addition in the Sum Insured without an associated increase in premium. (HERE THE PRODUCT SPECIFIC WORDINGS OF RENEWAL CB BENEFIT WILL COME)renewal premium

9. "**Day Care Centre"** means any institution established for day care treatment of illness and /or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-
   a) has qualified nursing staff under its employment;
   b) has qualified medical practitioner(s) in charge;
   c) has a fully equipped operation theater of its own where surgical procedures are carried out;
   d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

10. **"Day care Procedure/Treatment"** means medical treatment, and/or surgical procedure which is –
    a) undertaken under General or Local Anesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and
    b) which would have otherwise required hospitalization of more than twenty four hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.

11. **"Deductible"** is a cost-sharing requirement under this policy that provides that the Company will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will - apply before any benefits are payable by the Company. A deductible does not reduce the Sum Insured.

12. **"Dental Treatment**" Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

13. **"Disclosure to information norm"** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

14. **"Emergency Care"** Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health

15. **"Domiciliary Hospitalisation"** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    a) the condition of the patient is such that he/she is not in a condition to be moved to a hospital or,
    b) the patient takes treatment at home on account of non-availability of room in a hospital.

"Grace period" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period**.**

16. **"Hospital"** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

    i. has qualified nursing staff under its employment round the clock;
    ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;

iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

17. **"Hospitalization"** means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours

18. **"ICU (Intensive Care Unit) Charges"** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges

19. **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

    a) Acute Condition- is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b) Chronic Condition- is defined as a disease, illness or injury that has one or more of the following characteristics:
        1. it needs ongoing or long term monitoring through consultations, examinations, check-ups, and/or tests
        2. it needs ongoing or long term control or relief of symptoms
        3. it requires your rehabilitation for the patient or for the patient to be specially trained to cope with it
        4. it continues indefinitely
        5. it recurs or is likely to recur.

20. "**Injury**" means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

21. **"Inpatient Care"** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event

22. **"Intensive Care Unit"** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

23. **"Maternity expense/treatment"** -means -
    a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections) incurred during Hospitalization;

b) Expenses towards lawful medical termination of pregnancy during the Policy Period.

24. **"Medical Advise"** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

25. **"Medical expenses"** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

26. **"Medical Practitioner"** means a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license provided that this person is not a member of the Insured Person's family.

27. **"Medically Necessary Treatment"** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

28. **"Migration"** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

29. **Network Provider"** means hospitals enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an Insured by a cashless facility.

30. **"New Born Baby"** means baby born during the Policy Period and is aged up to 90 days.

31. **"Non-Network Provider"** means any hospital, day care centre or other provider that is not a part of the Network.

32. **"Nominee"** means the person named in the Proposal or Schedule to whom the benefits under the Policy is nominated by the Insured Person.

33. "**Notification of Claim**" is the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

34. **"Outpatient (OPD) treatment"** means the one in which the insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient

35. **"Portability"** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

36. **"Pre-existing Disease"** "Pre-existing disease (PED)" means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

"Pre-hospitalization Medical Expenses" means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

37. **"Post-hospitalization Medical Expenses"** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and

ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

38. **"Qualified Nurse"** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

39. **"Reasonable and Customary charges"** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

40. **"Renewal"** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

41. **"Room rent"** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

42. **"Specific waiting period"** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

43. **"Surgery"** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

44. **"Unproven/Experimental treatment"** means the Treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

ii. Specific Definitions (Definitions other than those mentioned under C(i) above)

1. **"Age"** means age of the Insured person on last birthday as on date of commencement of the Policy.

2. **"Ambulance**" means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

3. **"AYUSH Treatment"** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

4. **"AYUSH Medical Practitioner"** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy or Ayurvedic and or such other authorities set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license and acceptable to Us.

5. **"Basic Sum Insured"** means the amount specified against each Insured Person/s specified in the Schedule to this Policy, subject to terms, conditions and exclusions of this Policy.

   In case of policies with more than one year tenure, the Basic Sum Insured specified on the Policy is the limit for each year. These limits will lapse at the end of every year and fresh limits up to the full Basic Sum Insured as opted, will be available for the next Policy year.

6. **"Break in Policy"** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

7. **"Capital Sum Insured"** means the sum as specified in the Schedule to this Policy against the name of Insured / Insured Person, which sum represents the Company's maximum liability for any or all claims under the Accident benefit(s) during the Policy Period against the respective benefit(s).

8. **"Complete & Irrecoverable loss of Sight/Speech/Hearing"** means complete loss of sight/speech/hearing which cannot be treated or corrected.

9. **"Endorsement"** means written evidence of change to the Policy including but not limited to increase or decrease in the period, extent and nature of the cover agreed by Us in writing.

10. "**Family/Family Member**" means the Primary Insured Person whose name forms the first Insured Person, his/her lawful spouse, child/children, parents/ parent-in-laws and such other persons who are specifically mentioned in the Schedule to this Policy.

11. **"Family Floater"** means Policy wherein all Insured Person/s of a family are covered under a single Basic Sum Insured. Basic Sum Insured for family floater policy is the amount specified in the Policy Schedule which represents the Company's maximum total & cumulative liability for all Insured Person/s for any or all claims incurred during the Policy Period excluding Cumulative Bonus, Cumulative Bonus Enhancer, Restore Sum Insured, Capital Sum Insured and specific limits as available to the Insured Person/s as stated in the Policy Schedule.

12. **"Infertility"** is defined by the failure to achieve a clinical pregnancy after twelve months or more of regular unprotected sexual intercourse.

13. **"Insured/ You/ Your/ Yourself"** means an individual, who has proposed for Insurance and on whose name the Policy is issued.

14. **"Insured Person/s"** means the person(s) named in the Schedule of the Policy

15. **"Permanent"** means lasting for life long or forever.

16. **"Permanent Partial Disability"** means an accidental Injury caused by accident, which as a direct consequence thereof, disables any part of the limbs or organs of the body of the Insured person and which falls into one of the categories listed in the Table of Benefits.
17. **"Permanent Total Disability"** means an accidental Injury caused by accident, which as a direct consequence thereof totally disables and prevents the Insured Person from attending to any business or occupation of any and every kind or if he/she has no business or occupation, from attending to his/her usual and normal duties that last for a continuous period of 180 days except in case of physical severance of limbs, from the date of the accident, with no hopes of improvement at the end of that period and which falls into one of the categories listed in the Table of Benefits.

18. **"Policy**" means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

19. **"Policy period"** means the period between the inception date and expiry date of the Policy as specified in the Schedule to this Policy or the date of cancellation of this Policy, whichever is earlier.

20. **"Policy Schedule"** means the Policy Schedule attached to and forming part of Policy.

21. **"Policy year"** a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

22. "**Proposal and Declaration Form**" means any initial or subsequent declaration made by the Insured/ Insured Person/s and is deemed to be attached and forming part of this Policy.

23. **"Service Provider"** means the licensed entity who will provide identified preventive healthcare, medical assistance and personal services to the insured.

24. **"Sum Insured"** means the amount stated in the policy Schedule as such or limited to the specific insurance details in any Section of this Policy. The Sum Insured shall be subject at all times to the terms and conditions of the Policy, including but not limited to the exclusions and any additional limitations noted in the wording of each Section.

25. **"Third Party Administrator or TPA**" means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those Regulations

26. **"We/Our/Us"** means the Liberty General Insurance Limited

D. BENEFITS COVERED UNDER THE POLICY

SCOPE OF COVER

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse Reasonable and customary charges incurred towards medically necessary expenses up to the limits specified in the schedule against each benefit.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the sum of Basic Sum Insured, Cumulative Bonus, Cumulative Bonus Enhancer, Restore Sum Insured, Capital Sum Insured and specific limits as available to the Insured Person/s and stated in the Policy Schedule.

1. Hospitalisation Expenses

A. In-Patient Treatment Expenses

The Company undertakes to indemnify Reasonable and customary expenses to the Insured person against any disease or Any One Illness or any injury during the Policy Period and if such disease or injury shall require any such Insured Person, upon the advice of a duly qualified physician/Medical Practitioner to incur in-patient care expenses for medical/surgical treatment at any Hospital / Nursing Home in India, towards following expenses, subject to the terms, conditions, exclusions and definitions contained herein or endorsed.

i. Room, Boarding expenses
ii. Intensive Care Unit bed charges
iii. Doctor's fees
iv. Nursing Expenses
v. Surgical Fees, Operation Theatre Charges, Anesthetist, Anesthesia, Blood, Oxygen and their administration, Physical Therapy
vi. Prescribed Drugs and medicines consumed on the premises

vii. Investigation Services such as Laboratory, X-Ray, Diagnostic tests
viii. Dressing, Ordinary splints and plaster casts
ix. Cost of Prosthetic devices if implanted during a surgical procedure, and if recommended by the attending Medical Practitioner

B. Day Care Procedure/Treatment

The Company will indemnify Reasonable and customary medical expenses incurred on a treatment towards a Day Care procedure, where the procedure or surgery is taken by the Insured Person as an inpatient for less than 24 hours in a Hospital or standalone day care center but not in the Outpatient department of a Hospital.

2. Pre-Hospitalisation Expenses

The Reasonable and customary Medical Expenses incurred during the Policy Period for the period as mentioned in the Schedule, immediately before the Insured Person was hospitalised, provided that:

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
ii. There is a valid claim admissible under Part D 1.A (In-patient Treatment Expenses) or Part D 1.B (Day Care Procedure/Treatment) of the Policy.

3. Post-Hospitalisation Expenses

The Reasonable and customary Medical Expenses incurred during the Policy Period for the period as mentioned in the Schedule, immediately after the Insured Person was discharged following Hospitalisation, provided that:

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and
ii. There is a valid claim admissible under Part D 1.A (In-patient Treatment Expenses) or Part D 1.B (Day Care Procedure/Treatment) of the Policy.

4. Domiciliary Hospitalisation Treatment

The Company will indemnify medical expenses incurred by an Insured Person/s for medical treatment taken at his home in India which would otherwise have required hospitalization, on the advice of the attending medical practitioner as the Insured Person/s could not be transferred to a Hospital or a Hospital bed was unavailable and provided that

i. The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable & customary medical expenses for the duration of hospitalization.
ii. The Sum Insured is limited to 10% of the Basic Sum Insured for a Policy Year.
iii. If We accept a claim under this Benefit, We will pay for Pre-hospitalisation and Post-hospitalisation expenses up to 30 days in accordance with Part D. 2 & 3 of the policy.
iv. No payment will be made if the condition for which the Insured Person requires medical treatment is:
    a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract
    b. Infection including Laryngitis and Pharyngitis, Cough and
    c. Cold, Influenza,
    d. Arthritis, Gout and Rheumatism,
    e. Chronic Nephritis and Nephritic Syndrome,
    f. Diarrhoea and all type of Dysenteries including Gastroenteritis,
    g. Diabetes Mellitus and Insipidus,

h. Epilepsy,
i. Hypertension,
j. Psychiatric or Psychosomatic Disorders of all kinds
k. Pyrexia of unknown Origin.

5. Hospital Daily Cash Allowance

The Company will pay the amount as specified in the Schedule to this Policy against Hospital Cash allowance benefit for each continuous and completed period of 24 hours of hospitalization of the Insured Person/s for a maximum up to 10th day of continuous hospitalization., provided a valid claim is admissible under Part D 1.A (In-patient Treatment Expenses) of the Policy. A deductible of first 48 hours of hospitalization is applicable.

6. Emergency Local Road Ambulance Charges

The Company will indemnify Reasonable and customary expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following Accidental Bodily Injury/ illness / disease occurring during the Policy Period., provided that:

i) Our maximum liability shall be as specified in the Schedule to this Policy.
ii) There is a valid claim admissible under Part D 1.A (In-patient Treatment Expenses) of the Policy

The coverage also includes the cost of the transportation of the Insured Person from one Hospital to another nearest Hospital which is prepared to admit the Insured Person and provide necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person was first admitted, provided that the transportation has been prescribed by a Medical Practitioner and is Medically Necessary.

7. Organ Donor Expenses

The Company will indemnify Reasonable and customary organ donor's screening charges & the medical expenses for an organ donor's treatment for harvesting of the organ donated up to the amount as specified in the Schedule to this Policy, provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 (Amended)and the organ donated is for the use of the Insured Person, and
ii. We will not pay the donor's pre- and post-hospitalisation expenses or any other medical treatment or complication for the donor consequent on the harvesting, and
iii. A valid claim is admissible under Part D 1.A (In-patient Treatment Expenses) of the Policy.

8. Second Opinion

A second medical opinion service from our expert panel is available for all Insured Person/s seeking information that will give the Insured Person/s confidence in medical diagnosis and treatment plan. At the request of the Insured Person/s, the company shall arrange for a Second Opinion which is subject to the following:

i. This benefit can be availed only once during the policy Period by the Insured Person for any hospitalization and / or listed Critical illnesses.
ii. The Insured Person is free to choose whether or not to obtain the Second Opinion, and if obtained, whether or not to act on the same.

iii. The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon
iv. Any Second Opinion provided under the Benefit shall not be valid for any medico-legal purposes.

9. Nursing Allowance

This benefit provides for payment of a Reasonable and customary daily allowance, as specified in the Schedule to this Policy, towards engaging the services of a qualified nurse either at the Hospital or at the Insured Person's residence provided

- such services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to a disease / illness / injury for which the Insured Person has been hospitalized.
- A valid claim is admissible under Part D 1.A (In-patient Treatment Expenses) of the Policy
- A deductible of first 48 hours of hospitalization is applicable. The deductible will not be applicable in case of hospitalization due to relapse of same Illness/injury within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment may have taken.

10. Laser Eye Surgery

The Company will indemnify the Insured Person/s up to the limit specified in the Schedule to this Policy, for the Reasonable and customary charges incurred for correction of refractive errors by using laser surgery in case of compound myopic astigmatism in both eyes to the level of (-)5D and above.

Any payment under this clause shall be paid provided the Insured person (s) has:

i. Continuous Coverage of twenty four (24) months under this Cover with Us
ii. Such a treatment is payable only after prior approval of Medical Practitioner authorized by the Company or TPA mentioned in the Schedule to this Policy.

11. Vaccination for Animal Bite

The Company will indemnify for the Reasonable and customary charges incurred for Vaccination against Animal Bite of the Insured Person/s during the Policy Year maximum up to the limit specified in the Schedule to this Policy. These charges will be payable only if forming part of post animal bite treatment which is medically necessary and forming part of treatment recommended by the treating Doctor.

12. AYUSH Treatment#

The Company will indemnify Reasonable and Customary charges up to the Basic Sum Insured mentioned in the Policy Schedule, towards Medical Expenses incurred for the inpatient hospitalization treatment taken under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy provided that the hospitalization is for minimum 24 hours and is not for evaluation and/or investigation purpose only and treatment is availed in India and provided the treatment has undergone in:

i. Government hospital or in any institute recognized by government and/or accredited by Quality Council of India or National Accreditation Board on Health;
ii. Teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH);
iii. AYUSH Hospitals as defined hereinabove.

Exclusions specific to AYUSH Treatment#

The Company shall not make payment in respect of claims arising directly or indirectly out of or attributable or traceable to any of the following:

1. OPD / Day care treatment
2. Wellness and non-therapeutic treatment

3. Any Pre-Hospitalization and Post-Hospitalization Expenses

#Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024.

4. All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary.
5. Non- Prescribed medicines by treating physician, non-disclosed formulations & non-standardized preparations or Health Supplementary products will be excluded.
6. Any Pre or Post hospitalization AYUSH treatment taken before/pursuant to inpatient Allopathy treatment.

The above exclusions are in additions to the General exclusions listed under the Policy.

13. Restoration of Sum Insured

The Policy provides, as applicable to the relevant plan specified in the schedule to the policy, that, where the Basic Sum Insured is exhausted due to claims made and paid during the Policy Year or made during the Policy Year and accepted as payable, then the Company agrees to automatically make available a Restore Sum Insured equal to 100% of the Basic Sum Insured for the particular policy year, provided that:

a. The Restored Sum Insured will be utilized only after the Basic Sum Insured and Cumulative Bonus earned (if any) have been completely exhausted in that Policy Period; and
b. The Restored Sum Insured cannot be clubbed with balance if any available under the Basic Sum Insured and Cumulative Bonus earned if any.
c. The Restored Sum Insured can be used only for such claims as is admissible in terms of Part D 1.A (In-patient Treatment Expenses) incurred within Indian Territory.
d. The Restored Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an illness/disease for which a claim has been paid in the current policy year under Part D-1 of the Policy.
e. The Restored Sum Insured will be available during the Policy Year till it is exhausted completely.
f. Any unutilized restored amount cannot be carried forward to any subsequent Policy Year.
g. The Restored Sum Insured shall not be considered while calculating the Cumulative Bonus
h. The total amount of restored Sum Insured shall not exceed the Basic Sum Insured for that Policy Year.
i. In case of Portability, the credit for Sum Insured would be only to the extent of the Basic Sum Insured.

If the policy is a Family Floater, then the Restored Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Basic Sum Insured was exhausted and for whom we have not incurred or paid any claim during the current Policy Period.

14. Extended Policy tenure

In case the Insured Person/s is out of the country for a period of more than 15 days continuously and/or maximum up to 180 days, then this Policy will be extended for the number of days the Insured/Insured Person/s is/are out of the country.

If the Insured person/s is/are out of the country frequently within a Policy Year, the coverage will be extended for the number of days of the single visit which has maximum/ higher number of overseas days within a Policy Year.

In case of a Family Floater policy, the maximum number of days all Insured/Insured Person/s is/are out of the country for a period of more than 15 days continuously and/or up to 180 numbers of days continuously, together in a single visit shall be considered while extending the Policy tenure.

The Insured Person/s needs to intimate the requirement for extension of Policy tenure to the Company, before the Policy expiry date.

15. Obesity Treatment Cover

The Company will indemnify the Insured person/ for the Reasonable and customary Medical expenses incurred for In-patient Hospitalization treatment related to or for obesity maximum up to the amount mentioned in the Schedule to this Policy, where the Body Mass Index of the Insured Person(s) is greater than 40 and with medical co-morbidities as mentioned below :

i. Respiratory: Obstructive sleep apnea, Pickwickian syndrome (obesity hypoventilation syndrome)
ii. Cardiovascular: Coronary artery disease, left ventricular hypertrophy, coronary pulmonale, obesity-associated cardiomyopathy, accelerated atherosclerosis, and pulmonary hypertension of obesity

Any payment under this clause shall be paid provided the Insured person (s) has:

iii. Continuous Coverage of thirty six (36) months under this Cover with Us
iv. Such a treatment is payable only after prior approval of Medical Practitioner authorized by the Company or TPA mentioned in the Schedule to this Policy.

16. Infertility Treatment Cover

The Company will indemnify Reasonable & customary Medical expenses incurred for In-patient Hospitalization or Day care Procedure during the Policy period for the treatment of Infertility subject to a limit as specified in the Schedule to this Policy and shall be our maximum liability in respect of all Insured Persons under this cover. The claim under this cover is admissible only once during lifetime of the Insured Person up to the maximum limits specified in the Policy Schedule. If any claim is payable to any Insured Person under this cover in any particular Period of Insurance, the benefit under this Clause shall not be available for any subsequent Renewal for any Insured Person irrespective of the amount claimed in the expiring Policy.

We will not be liable to make any payment in respect of the following:

i. Infertility services beyond 8 weeks of pregnancy;
ii. Infertility services for an Insured person who have undergone voluntary sterilization procedures,
iii. Infertility services for an Insured Person/s having two live children; and
iv. Infertility services for women with natural menopause at the age 40 years and older

Any payment under this clause shall be paid provided you and your spouse has:

i. Continuous Coverage of thirty six (36) months under this Cover with Us
ii. No claim has been paid to any Insured Person during any Policy Year under this cover and/or maximum limit to this cover as mentioned in the Schedule to this Policy is not exhausted.

17. Maternity and Child Care

1. The Sum Insured opted under this cover is separate than the Basic Sum Insured and applicable up to the limits as stated against each category in the Policy Schedule. The cover is available only to families covered under Family floater.

A. Maternity Care
The Company will indemnify the Reasonable & customary Medical expenses for the delivery of a baby (including caesarean section) and/or expenses related to medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the insured person, provided that,

i. Our maximum liability per delivery or termination shall be limited to the amount specified in the policy Schedule as per the plan opted.
ii. We will pay the Medical Expenses of pre-natal and post-natal hospitalization per delivery or termination upto the amount stated in the policy Schedule
iii. Waiting period of twenty four (24) months from the date of issuance of the first policy with us, provided that the policy has been renewed continuously with us without break for you & your spouse insuring under this cover.
iv. Any complications arising out of or as a consequence of maternity/child birth will be covered within the limit of Sum Insured available under this benefit
v. Medical expenses for Ectopic Pregnancy are not covered under this benefit. However, these expenses are covered under Part D 1. A. (In-patient Treatment Expenses)

B. Child Care
The Company will indemnify the Reasonable and customary Medical expenses incurred for the new born baby up to 90 days of age, provided that there is a valid claim payable under Part D 17.A. (Maternity Care), maximum up to the limit as stated in the Policy Schedule under 'Child Care' benefit.

C. New Born Vaccinations
The Company will indemnify the Reasonable and customary Medical expenses incurred for the new born baby's vaccinations up to 3 years of age maximum up to the limit specified in the Policy Schedule subject to a valid claim payable under Part D 17.A. Maternity Care.

D. New Born Screening Expenses
The Company will indemnify the Reasonable and customary Medical expenses incurred for the new born baby's screening expenses done within the hospitalization period same as maternal hospitalization period up to the limit specified in the Policy Schedule subject to a valid claim payable under Part D 17.A. Maternity Care.

If a newborn screening test comes back positive (abnormal), further Reasonable and customary testing expenses to determine whether the baby has a particular condition shall be covered within the limits as specified in the Policy Schedule against this cover.

E. Umbilical Cord Stem Cell Banking Allowance

The Company will indemnify the Reasonable and customary expenses incurred for the new born baby's umbilical cord stem cell banking limited for the first year banking allowance up to the limit specified in the Policy Schedule subject to a valid claim payable under Part D 17.A. Maternity Care. The Company indemnifies Stem Cell Banking allowance to store your baby's cord blood in a private cord blood bank for the new born child or your family's use.

18. Preventive Care

The Company will provide below additional benefits which would help in preventing and/or bettering current Health condition/s.

The below services will be provided by Us/Our appointed service provider and can be availed anytime during the policy period and there are no restrictions on the number of times the facility can be utilized.

1. <u>First Medical Opinion:</u>

A First medical opinion service from our expert panel is available for all Insured Person/s seeking information that will give them confidence in their medical diagnosis and treatment plan. At the request of the Insured Person/s, the company shall arrange for a First Opinion which is subject to the following:

i. A First Medical Opinion service provides an unbiased opinion on simple medical queries that have not been taken to a medical expert as of yet.
ii. This benefit can be availed only once during the Policy Year by each Insured Person covered on Individual or Family Floater policy.
iii. The Insured Person is free to choose whether or not to obtain the First Opinion, and if obtained, whether or not to act on the same.
iv. The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any First Opinion or for any consequences of actions taken or not taken in reliance thereon
v. Any First Opinion provided under the Benefit shall not be valid for any medico-legal purposes.

2. <u>Live Health Talk:</u>

A unique offering where the Insured Person(s) can log in through their unique login ID on the Portal and schedule a live chat with a practicing doctor to discuss health problem.

3. <u>Electronic Medical Record Management (EMRM):</u>

Our Portal provides storage for all your medical documents and reports centrally in one location. With EMRM you may retrieve your medical documents at your convenience through the internet. This facility provides you easy accessibility of the documents anytime and anywhere in a secured way.

4. <u>Fortnightly Newsletters:</u>

Relevant and Crisp Fortnightly Publication on Health & Lifestyle Awareness would be available for you on the Portal.

19. Health 360°

The Company covers below listed benefits to ensure the Insured person/s Health & Wellness under this Policy by offering services & incentivizing rewards as mentioned below.

A. Delight Healthcare

The Insured Person/s can avail discounts on outpatient consultation, pharmaceuticals and Diagnostic tests through our empaneled Network Providers. The list of such Network Providers will be updated from time to time and can be obtained from Our website, mobile application or by calling Our call centre. We will assist in scheduling appointments for consultation and diagnostic tests at a time convenient to the Insured Person. Alternatively the Insured Person may also schedule his/her own appointment themselves by contacting the Network Provider or through the mobile application. The Insured Person/s can avail these facilities as many number of times as wishes to avail.

In all cases the medical professional suggested by the Company shall act in a medical or legal capacity on behalf of You only. The Company assumes no responsibility for any medical advice given by the medical professional. You shall not have any recourse to the Company by reason of its suggestion of a medical professional or due to any legal or other determination resulting therefrom.

The services are on arrangement basis and utilizing these services from the Company's empaneled network provider would be at the discretion of the Insured member. You are responsible for the cost of services arranged by the Company on behalf of You or a covered Immediate Family member.

1. OPD consultation-
   The Company arranges family physician as well as specialist consultations at discounted rates from the Network Providers. The Insured Person/s can also store the prescription letters and bills in the electronic health portal system.

2. Diagnostic services-
   The Company arranges diagnostic facilities at discounted rates from the Network Providers. The insured person can avail this facility as many number of times as the person wishes to avail. The insured person can also store these medical test reports and bills in the electronic Health portal system.

3. Pharmacies
   If the Insured Person/s wants to obtain medicines and consumables prescribed by a Medical practitioners, he/she can avail home delivery facilities through our web portal or mobile application. These medicines and consumables are available at discounted rates subject to a valid prescription.

B. Concierge Healthcare-

The Company offers integrated healthcare services inculcating the advancement in technology and with a member centric approach. The Insured Person/s is provided individual access to our health portal which will be available at Company's website and Mobile application where he/she can perform various healthcare activities.

1. Health Risk Assessment (HRA)

Step 1 - Health questionnaire-
Once the Profile of the Insured Persons is created on the Health Portal or Mobile application, this questionnaire will be available for doing own Health Risk assessment. We will aid the Insured Person/s to complete the questionnaire whenever required.

Step 2- Electronic Health records-
Insured Person/s can store the medical tests reports, prescriptions and other consultation papers in the personalized portal and which gets digitalized to help create a complete health profile of the Insured person/s. These medical test reports along with HRA as specified above, will provide a health score to depict the health status of the Insured Person/s.

The Health score will be driven basis the information provided in areas of Medical history, stress, diet and lifestyle which ranges from 1 to 100 enabling us to identify the need of Step 3 as mentioned hereunder.

Step 3 -Health Screening-
If the health scores depicts healthy status, there will be no trigger for medical screening. But if the score depicts unhealthy status, medical screening is advised to the Insured Person/s which he will have to get it done at his own cost or focus on 'Target Risk Assessment' post identification of the risk factor for improving his/hers overall well-being.
"Targeted Risk Assessment", which basically takes a deep dive in the identified risk areas to establish the focus points in that particular risk area. This is based on the Health screening done subsequently after the HRA. It's a specific tracking if the client suffers from any of the Non Communicable Diseases like Diabetes, Blood Pressure, Thyroid or any other diseases which in turn call for a Health coach who will prompt for the next steps which is a 'Targeted Risk Assessment.

Step 4- Disease management program-
The Insured Person/s also gets further triggers for disease management program as specified hereunder pertaining to the current health status if required.

2. Disease Management Program-

Those who get detected or get assessed as high risk in the health risk assessment or are already suffering from chronic diseases, the Company offers variety of disease management programs. This service aims to help the Insured Person/s cope with their disease and to show them ways of dealing with them in everyday life. The Disease management Program aim to improve the Insured Person/s quality of life. Following are the names of Disease Management programs.

- Asthma Management
- Pre-Diabetes / Diabetes Management
- Hypertension
- Heart Related Management
- Maternity Management

- Tropical Disease Management

Based on the Disease Management Program identified, we will assign a Health Coach for online Diet consultation & tracking mechanism, indulging the Insured Person/s into physical activities, encouraging for meditation & breathing techniques at home or online counselling through our health portal/mobile application.

Health coach-

The Insured Person/s will be assigned a dedicated health coach who will take care of the complete wellbeing of the Insured person. This service will offer immediate and complete assistance to the person looking after his/her day-to- day health care. Post the complete profile building of the Insured Person/s done on online portal, health coach will interact with the Insured Person/s as per health requirements.

3. Dedicated Health Professional

The Company offers 24/7 live Health Chat via online Health portal and telephonic call service to discuss health and other various lifestyle related issues from expert panel of empaneled doctors and health professionals. The below services may be availed anytime during the policy period and there are no restrictions on the number of times the facility can be utilized.

- Ask Doctor – for basic health related conditions and medications
- Ask Nutritionist – for diet and nutrition considerations depending on lifestyle
- Ask Counselor – confidential counseling by professionals, crisis intervention etc.

4. Wellness Rewards :

The Company has kept a provision to Earn & Burn Rewards by way of 'Wellness Reward Program'. The Rewards can be earned by performing various activities as listed below 'Table 1. Wellness Reward' upto the maximum limits as specified under every category during every continuous Policy year and Burn it whenever required against array of our facilities provided as mentioned hereunder 360which would help you to improve your overall Health status whilst using the Rewards earned by you as follow.

a. For an Individual as well as Family Floater Policy, the earning of Wellness Rewards shall be considered on Individual member basis upto the maximum limits as specified under every category or sum of all Rewards earned by all Insured Persons maximum upto 10% of premium paid in the expiring Policy Period whichever less.
b. We will specify the Wellness Rewards-Earn & Burn categories as well as Earned but non-utilized Rewards in the Policy Schedule. The details of Wellness Reward also would be available at our Health portal or Mobile application using personalized security access.
c. All Rewards earned under this Section of the Policy are valid upto four Policy years of renewal of this Policy including the Grace Period applicable to the preceding Policy and would not be carried forwarded thereafter.
d. Each Reward earned by the Insured Person will be equivalent to 0.50 INR.

e. The Wellness Reward can be Earned in the following ways as mentioned under Table 1. Wellness Reward: Earn.

Table 1 Wellness Reward: Earn

Sr. No.	Activities for Earning Wellness Rewards			Rewards/ unit earned by Individual	Max Rewards earned by Individual Per Policy Year
I	Solution to Sedentary Lifestyle	HRA outcome without any adverse report	Cover 2.5 to 3.5 lakhs steps in a month	100/month	500
		HRA Outcome of having Large waist size (> 40 inches)	Cover minimum 2 lakhs steps in a month	100/month	500
			Cover above 2 lakh steps in a month	150/month	1000
		Blood pressure for a known case of Hypertension	Blood Pressure is below or equal to - SBP:120-140 mm/Hg DBP: 80-90 mm/Hg SBP- Systolic Blood Pressure; DBP – Diastolic Blood Pressure	150/month	500
		Blood sugar levels for a known case of Diabetes	HBA1C within normal limits ≤ 5.6	150/quarterly	500
		Lipid profile Level for a known case of Dyslipidemia	Lipid level are normal within range as applicable to the Laboratory	150/quarterly	500
		Body Mass Index (BMI) for a known case of High BMI Insured Person /s >=30 optimum BMI	BMI between 31 to 35 and reduce your BMI to the Optimum range	100/quarterly	200
			BMI between 35 to 39 and reduce your BMI to the optimum range	150/quarterly	300
			BMI between 40 to 42 and reduce your BMI to the optimum range	250/quarterly	500

II	Get active Rewards	Can be availed by providing attendance Register/letter/medal/trophies/BIB number (as applicable) from the respective facility provider.	Participate in professional sport events like Marathon/Cyclothon/Swimathon	100 /event	500
	Online Screening	On completion of HRA on Health Portal/Mobile application	HRA Completion within a month from Policy Inception Date	200	200
III	Prophylactic Screening	The Insured person (s) can earn wellness reward by undergoing the below listed medical tests at his own cost, irrespective of the results of screen tests performed.			
		Heart Related Monitoring	a. ECG	50/quarterly	100
			b. 2D echo/ TMT	100/ quarterly	200
		Blood Sugar Monitoring	a. FBS & PPBS	50/ quarterly	100
			b. HbA1C	75/ quarterly	200
		Thyroid/Lipid Monitoring	a. TFT (Thyroid Function Test)	100/ quarterly	200
			b. Lipid Profile	100/ quarterly	200
		Tests for Female Insured Person	a. PAP Smear	200/ quarterly	300
			b. USG Abdomen & Pelvis	150/ quarterly	300
			c. Mammogram	250/ quarterly	500
		Test For Male	a. Prostate Specific Antigen (PSA)	150/ quarterly	300
			b. Any other test as suggested in Health Screening by Us.	150/ quarterly	300
IV	Family Rewards	Fit Kid (Age: 5-18 years) applicable only for a family floater plan insuring child. The Rewards are available for a child participating in the Sports at multiple levels. Can be availed by providing Sports Certificate provided by the School/State/National Sports authorities.	a. School level	20/sport	50
			b. State level	50/sport	100
			c. National level	100/sport	200

f. The Insured Person can Burn these accumulated Rewards against categories as mentioned in Table 2 Wellness Reward: Burn.

Table 2 Wellness Reward: Burn

Sr. No	Categories to Burn the Rewards
a.	The Insured Person (s) may redeem the reward points (as available) while paying the applicable discounted rates to the Network Provider for the facilities as mentioned under 'Health 360°: Delight Healthcare'.
b.	Dental Care except cosmetic treatment
c.	Cost of Vaccinations
d.	Cost of Spectacle Lenses
e.	Laser surgery for correction of refractory errors
f.	Any Hospitalizations which is Non-admissible as per the Policy terms and conditions as specified under ' In-patient Hospitalization'
g.	You can also redeem your Rewards against Claim of yours/your Family member/s who are insured with Us under any retail Health Indemnity product if their Sum Insured is exhausted and/or against any Non admissible expenses.
h.	Discount on premium while renewing your Policy. For more details, please refer clause 19(B)(4)(a).

20. Stay Fit Perks

The Policy provides additional perk equivalent to the amount specified in the Benefit schedule as applicable on renewal of Policy after every two claim free Policy years The accumulated Stay fit perk can be utilized from third Policy year of continuous renewal of the same Policy against any non-medical expenses subject to Claim admissible under Part II. A of the Policy.

a. For a Family Floater policy, Stay Fit Perk shall be available only on floater basis and shall accrue only if no claim has been made in respect of any Insured Person covered during the two expiring Policy Years. The Stay Fit Perk which is accrued during the claim free Policy Years will only be available to those Insured Person/s who were insured in such claim free Policy Years and continue to be insured in the subsequent Policy Year.
b. If the Insured Person/s in the expiring Policy are covered on a Floater Basis and the Policy renewal for such Insured Person/s is done by splitting the floater Sum Insured into 2 or more floater / individual covers, then the Stay Fit Perk of the expiring Policy shall be apportioned to such renewed Policy/ies in proportion to the Sum Insured under each of the renewed Policy/ies.
c. If the Insured Person/s in the expiring Policy are covered on an Individual basis and thereby enjoy separate Stay Fit Perk in the expiring Policy/ies, and such expiring Policy/ies is renewed with the Company on a Floater Basis, then the Stay Fit Perk carried forward under such renewed floater Policy would be the least of the Stay Fit Perk /s earned under the expiring Policy/ies.

21. Renewal Health Check-up

The Insured Person/s above18 years of age at inception of the Policy is/are entitled to a annual health check-up, on Cashless basis, at a diagnostic center specified by the Company. This benefit is available

irrespective of the claims made under the Policy and subject to continuation of Policy with Us. This is available for the Insured Person/s who were insured with Us for the above specified period and continue to be insured in the subsequent Policy Year under the same Policy Plan.
If the Annual checkup reports are abnormal and the Insured Person/s succeeds to bring it to normal, he/she can earn Wellness Rewards as mentioned under Part D. 19 'Health 360°-Table 1 'Wellness Reward'.

Plan	Sum Insured (in Lakhs)	List of Investigations
Essential	10, 15, 20, 25, 30, 50	Complete blood Count, Routine Urine Analysis, Blood group, ESR, Fasting Blood Sugar, S. Cholesterol, SGPT, Creatinine, ECG
Optimum	10, 15, 20, 25, 30, 50	Complete blood Count, Routine Urine Analysis, Blood group, ESR, Fasting Blood Sugar, S. Cholesterol, SGPT, Creatinine, ECG
Optimum Plus	75, 100	Complete blood Count, Routine Urine Analysis, Blood group, ESR, Fasting Blood Sugar, Lipid profile, Kidney Function Test, Medical Examination, ECG

22. The Insured Person who do not make claim, will be rewarded with any one of the below two options as per the choice/ express consent of the Insured Person at the time of every renewal:

A. Cumulative Bonus

This Policy provides for auto increase in Basic Sum Insured by 10% of the Basic Sum Insured for every claim free Policy year up to a maximum of 100% of the Basic Sum Insured.

a. For a Family Floater policy, the Cumulative Bonus shall be available only on floater basis and shall accrue only if no claim has been made in respect of any Insured Person during the expiring Policy Year. The Cumulative Bonus which is accrued during the claim free Policy Year will only be available to those Insured Persons who were insured in such claim free Policy Year and continue to be insured in the subsequent Policy Year.
b. If the Insured Person/s in the expiring Policy are covered on a Floater Basis and the Policy renewal for such Insured Person/s is done by splitting the floater Sum Insured into 2 or more floater / individual covers, then the Cumulative Bonus of the expiring Policy shall be apportioned to such renewed Policy/ies in proportion to the Sum Insured under each of the renewed Policy/ies.
c. If the Insured Person/s in the expiring Policy are covered on an Individual basis and thereby enjoy separate Cumulative Bonus in the expiring Policy/ies, and such expiring Policy/ies is renewed with the Company on a Floater Basis, then the Cumulative Bonus carried forward under such renewed floater Policy would be the least of the Cumulative Bonus/s earned under the expiring Policy/ies..
d. Entire Cumulative Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace period whichever is later.

e. Where a portion of/ full Cumulative Bonus earned is utilized following a claim, the balance if any available will be carried forward for the immediate renewal. However, the Policy would not qualify for any fresh Cumulative Bonus on the immediate Policy renewal.

B. Discount in Renewal Premium

As per the choice/ express consent of the Insured Person at the time of every renewal Insured can choose Discount in renewal premium in the in lieu of auto increase in Basic Sum Insured (Loyalty Perk /Cumulative Bonus) for every claim free Policy year

23. Change in Plan/ Enhancement of Basic Sum Insured

Basic Sum Insured can be enhanced and/or existing Policy Plan may be changed only at the time of renewal subject to no claim having been lodged/ paid under the earlier policy/ies and as per the board approved underwriting policy of the Company. In all such case of increase in the Basic Sum Insured and/or Policy cover(s), waiting period will apply afresh in relation to the amount and/or cover(s) by which the Basic Sum Insured has been enhanced and/or Policy Plan has been changed.

24. Emergency Assistance Services-

The below services will be available when the Insured/Insured member/s is/are more than 150 kilometers away for the continuous no. of days not beyond 90 days, within Indian territory, from their residential address as provided in the Proposal Form. The services would be provided by us /through our appointed Service provider, with prior intimation and acceptance by the Company and can be availed anytime during the policy period on Cashless basis and there are no restrictions on the number of times the facility can be utilized. We/ our Service provider completely arranges and pays reasonable and customary expenses towards assistance services without limits on the covered cost. No claims for Reimbursement will be accepted.

i. **Medical Consultation, Evaluation and Referral**- In case of any emergency situation, We/our Service Provider will evaluate, troubleshoot and make immediate recommendations including referrals to qualified doctors and/or hospitals. The Company shall arrange the appointment with the medical consultant however, the consultation fees will be borne by the Insured Person.

ii. **Medical Monitoring and Case Management-** A team of doctors, nurses, and other medically trained personnel would be in regular communication with the attending physician and hospital, monitors appropriate levels of care and relay necessary and legally permissible information to the members of the Family / employer.

iii. **Emergency Medical Evacuation-** If the Insured / Insured member/s becomes ill or injured in an area where appropriate care is not available, the Company /via Service Provider at its expense will intervene and use available transportation equipment and personnel necessary to evacuate the Individual safely to the nearest facility for a higher medical care on Cashless basis. Such emergency medical evacuation would be done either by ground or air solely at the discretion of the Company. Emergency Air Ambulance Charges: The Company will arrange Air Ambulance services on Cashless basis provided that:

a) The treating Medical practitioner certifies in writing that the severity or nature of the Insured Persons illness or injury warrants the Insured Persons requirement for Air Ambulance

b) The transportation expenses under this benefit include transportation from one Hospital to another Hospital for the purpose of providing a high standard of medical care to the Insured Person following a Medical Emergency.

iv. **Compassionate Visit:** When an Insured Peron is travelling alone and will be hospitalized for more than seven (7) consecutive days, The Company/ Service Provider will provide economy, round-trip, common carrier or an appropriate means of transportation to the place of hospitalization for a designated family member or a friend.

Procedure for availing Emergency Assistance Service:
In order to avail the emergency services, Insured person/s need to call Us on our toll free number 1800-266-5844 and provide the Policy number and member ID for verification purpose. Once the verification is done We/Our Service Provider will evaluate and arrange for the emergency assistance services as claimed and available in the policy.

25. Coverage for Modern Treatments:

The following procedures will be covered (wherever medically indicated) either as in patient or as part of domiciliary hospitalization or as day care treatment in a hospital upto 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. BronchicalThermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

OPTIONAL COVER(S)

The Optional Covers as stated below shall be available only if the same is specifically mentioned in the Policy Schedule and available on payment of additional premium as applicable. The Insured has an option to select the cover/s either on individual /combination basis, along with the covers specified under Parts D. Scope of Covers of the Policy.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the sum of Basic Sum Insured, Cumulative Bonus, Cumulative Bonus Enhancer, Restore Sum Insured and specific limits as available to the Insured Person/s and stated in the Policy Schedule.

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse Reasonable and customary charges incurred towards medically necessary expenses up to the limits specified in the schedule against each benefit.

1. Cumulative Bonus Enhancer

The Cumulative Bonus as available under Part II (Scope of Cover) can be enhanced by 25% of the Basic Sum Insured at every claim free Policy Year renewal maximum upto 150% of the Basic Sum Insured provided that:

a. The total Cumulative Bonus available under the Policy shall be subject to per Policy Year and maximum upto the limits as per the Plan opted and available under the Policy Schedule,
b. We would not pay separate Cumulative Bonus as stated under Part D.22 ' Cumulative Bonus' of the Policy,
c. The eligibility of this benefit is as per the terms and conditions stated under Part D.22 'Cumulative Bonus' of the Policy.
d. In case a Claim is made during a Policy year, the accrued Cumulative Bonus Enhancer would reduce by 25% of the expiring Basic Sum Insured in the following year. There would not be any reduction in the base Sum Insured, only the accrued Cumulative bonus will get reduced to the extent of Sum Insured that has been increased through Cumulative Bonus Enhancer.

2. Out Patient Treatment (OPD) Cover

The Company will pay Reasonable & customary charges for the Out Patient treatment incurred by the Insured Person(s) on Individual limit basis during the Policy Year, maximum up to the limit specified in the Schedule to this Policy against this cover, which is separate and not forming part of the Basic Sum Insured as mentioned in the Policy Schedule. These charges will be payable only if the Insured Person (s) consults a specialist consultant/specialist medical practitioner on Outpatient basis for the illness/injury contracted during the policy period. The Company will pay towards following expenses, subject to prescription from the treating specialist consultant/specialist medical practitioner.

a. Nursing Expenses
b. Physical Therapy (Physiotherapy) expenses of a specialist Physiotherapist supported by a prescription from the treating specialist consultant/specialist medical practitioner as a medically necessary treatment
c. Prescribed Drugs and medicines
d. Investigation Services such as Laboratory, X-Ray, Diagnostic tests
e. Dressing, Ordinary splints and plaster casts

3. Critical illness & Personal Accident cover:

This optional cover allows the Insured person to select a package of Critical illness & Personal Accident cover available on individual basis.

This cover pays onetime benefit if the Insured contracts any listed ' Critical illness' or sustains any bodily injury during the Policy period causing Accidental Death, Permanent Total Disablement or Permanent Partial Disablement.

The Covers as mentioned under 'Section 1' and 'Section 2' below need to be opted together.

Section. 1

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this optional cover and the terms, conditions, general exclusions stated in this Policy, to pay the limits on a lumpsum basis, not forming part of Basic Sum Insured, in relation to the Insured Person/s as stated under Schedule to this Policy on occurrence of an Insured Event as stated below, under this optional cover. The Policy for this Cover i.e. Critical illness & Personal Accident cover will be ceased after the claim has been made and paid to the Insured Person towards any of the listed Critical Illness however the Policy remains renewable for other available covers as specified in the Policy Schedule.

Insured event: For the purpose of this optional cover and the determination of the Company's liability under it, the Insured Event in relation to the Insured Person/s, shall mean any illness, medical event or surgical procedure as specifically defined below which was first diagnosed more than 90 days after the commencement of first Policy Period and the Insured person survives the illness by 30 days or more, from the date of diagnosis and shall include the:

a) First Diagnosis of the below-mentioned Illnesses more specifically described below:

1. Cancer of Specified Severity;
2. Kidney Failure requiring regular Dialysis
3. Multiple sclerosis with persisting symptoms

b) Undergoing for the following surgical procedures for the first time, more specifically described below:

4. Major Organ / Bone Marrow Transplant;
5. Open Heart Replacement or Repair of Heart Valves;
6. Open Chest CABG ;

c) Occurrence of the following medical events more specifically described below:

7. Stroke Resulting in Permanent Symptoms;
8. Permanent Paralysis of Limbs;
9. Myocardial Infarction (First Heart Attack of Specified Severity);

The Insured Event under this cover and the conditions applicable to the same are more particularly defined below:

1. <u>Cancer of Specified Severity</u>

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded -

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

2. Myocardial Infarction (First Heart Attack of Specified Severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:
   i. Angioplasty and/or any other intra-arterial procedures

4. Open Heart Replacement or Repair of Heart Valves

I. The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s).The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Kidney Failure requiring regular Dialysis

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

6. Stroke resulting in Permanent Symptoms

I. Any cerebral vascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient Ischemic Attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

7. Major Organ/Bone Marrow Transplant

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

8. Permanent Paralysis of Limbs

I. Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

9. Multiple Sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

In case where the Insured Person has selected this optional cover and has made a valid claim under any one of the named Critical Illnesses then, the Company will pay the lump sum amount as specified in the Policy Schedule. In this case, the claim will not be payable under Part D.1.A. (In- patient Treatment Expenses). The Insured Person can make a claim for any of the named Critical Illnesses, under this optional cover, only once during his lifetime.
In case where the Insured Person has not selected this optional cover, a valid claim will be payable under Part D.1.A. (In-patient Treatment expenses) of the policy.

Section. 2

Section 2.1 Personal Accident Cover:

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, General Exclusions stated in the Policy, to pay the Capital Sum Insured as stated under the Schedule to this Policy, on occurrence of the Insured Event as stated below:

- Insured event: For the purposes of this optional cover and the determination of the Company's liability under it, Insured Event in relation to any Insured Person/s, shall mean Injury sustained during the Policy Period which shall be the sole and direct cause of i) Accidental Death ii) Permanent Total Disablement iii) Permanent Partial Disablement as described hereunder.

The Capital Sum Insured opted under this Optional cover is separate than the Basic Sum Insured and allows the Insured person(s) for opting upto 150% of the Basic Sum Insured as stated particularly in the Policy Schedule.

The compensation under more than one event as stated above, for same period of disability shall not exceed the Capital Sum Insured.

i. Accidental Death:

If an Insured Person/s suffers an accident during the Policy Period and this is the sole and direct cause of his death within 12 months of such accidental Bodily Injury sustained, then We will pay the Sum Insured as mentioned in the Policy Schedule.

The Policy terminates for the insured person for whom we have received the claim under this cover. In case of a death of the Policy holder, this Policy shall continue till the end of the Policy Period. If the other Insured Person/s wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of an Insured.

ii. Permanent Total Disability

If an Insured Person/s suffers an accident during the Policy Period and this is the sole and direct cause of his permanent total disability in one of the ways detailed in the table below, within 12 months of such accidental Bodily Injury sustained, then We will pay 100% of the Capital Sum Insured for the benefits listed below.

Permanent Total Disability – Table of Benefits Loss of:
Limbs (both hands or both feet or one hand and one foot)
Loss of a limb and an eye
Complete and irrecoverable loss of sight of both eyes
Complete and irrecoverable loss of speech & hearing of both ears

In this benefit

a) Limb means a hand at or above the wrist or a foot above the ankle.
b) Loss of Limb means physical separation of a limb above the wrist or ankle respectively

In case of physical severance of Limbs, waiting period of 180 days shall not be applicable and the claim would be payable immediately subject to admission of claim as per the Policy terms and conditions and submission of all necessary documents / information and any other additional information required for the settlement of the claim.

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iii. Permanent Partial Disability

If an Insured Person suffers an Accident during the Policy Period and within 12 (twelve) Calender months from the date of the Accident this is the sole and direct cause of his permanent partial disability in one of the ways detailed in the table below, then We will pay the percentage of the Capital Sum Insured shown in the table.

Permanent Partial Disability - Table of Benefits	
Loss of	% of CSI
Each arm at shoulder	70%
Each arm to a point above elbow joint	65%
Each arm to a point below elbow joint	60%
Each hand at the wrist	55%
Each thumb	20%
Each index finger	10%
Each other finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each leg up to the center of tibia	45%
Each foot at the ankle	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%
Any other Permanent Partial Disability	% as assessed by Registered medical practitioner

The compensation under more than one event as stated above, for same period of disability shall not exceed the Capital Sum Insured stated under this cover.

In case of multiple claims under Permanent Partial Disability arising due to multiple events during the Policy period, the total claim payable amount shall not exceed the Capital Sum Insured stated under this cover.

Section 2.2 Adventure Sports Cover

If an Insured Person suffers an Accident while the Insured Person is engaged in an adventure sport carried out in accordance with the guidelines, codes of good practice and recommendations for safe practices as laid down by a governing body or authority during the Policy Period and this is the sole and direct cause of his/her Death or Permanent total disability or Permanent partial disability in one of the ways then the Company will pay up to the Sub Limit specified in the Policy Schedule forming part of the Capital Sum Insured and shall be payable in accordance with the Table as mentioned above under Section 2.1.Personal Accident cover, provided that:

The following exclusions listed under Part D. 35 General Exclusion will stand deleted for this Option:

Treatment/loss arising from Insured Person's participation in scuba diving, engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parachuting, hang gliding, rock or mountain climbing, winter sports, mountaineering (where ropes or guides are customarily used), caving or potholing, hunting or equestrian, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), polo, snow and ice sports, professional sports.

Section 2.3 Risk Categorization

Risk Group I: Doctors, Lawyers, Accountants, Architects, Consulting engineers, Teachers, Bankers, Builders, Contractors, Engineers on site engaged in superintending functions only, Veterinary Doctors, business owners wherein the business is not dealing in hazardous goods or not involving manual labor, Persons engaged in clerical functions & administrative functions and such other persons engaged in occupations of similar hazard listed above.
Risk Group II: Professional Athletics & Sportsmen, Wood working Machinists, Workers, Mechanics, Drivers, Manual laborers (except those falling under Group III) & such other persons engaged in occupation of similar hazard listed above.
Risk Group III: Persons working in underground mines, explosives, magazines, workers involved in electrical installation with high tension supply, demolition workers, Jockeys, Circus personnel, Persons engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, skiing, ice hockey, ballooning, hand gliding, river rafting, polo, persons working as Air Crew and Ship Crew, and such other persons engaged in occupation of similar hazard listed above.

4. Worldwide coverage

The Company will indemnify up to the amount specified in the Policy Schedule forming part of the Basic Sum Insured for the emergency care Medical Expenses incurred outside India, in respect of the Insured Person incurred during the Policy Year, provided that:

i. The Insured person/s is/are outside India for the purpose other than undergoing medical treatment/procedure
ii. Any illness, medical event or surgical procedure for which the Hospitalization has occurred, which was first diagnosed whilst the Insured Person/s is/are outside India.
iii. The treatment is Medically Necessary and has been certified by a Medical Practitioner as an Emergency care which cannot be deferred till the date of Insured Person/s return/s to India.
iv. The intimation of such hospitalization to the Company or our TPA is within 24 hours of admission.
v. The Emergency Medical Expenses incurred during In-patient Hospitalization only shall be covered.
vi. Pre-existing disease/s as on commencement date of the first Policy with us and any complications arising from the same shall not be covered until 36 months of continuous coverage have elapsed, since inception of your first Policy with Us & with this benefit.

vii. Any payments under this benefit will only be made in India, in Indian Rupees and on reimbursement basis. The payment of any claim will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for payment of the claim under this benefit.

viii. Waiting Periods of 30 days, First Year, Two Years, Three Years as stated under General Exclusions Part E. 1. 2. and 3. of the Policy shall be waived off under this cover.

ix. We shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

x. The cover is available for a maximum period of 180 consecutive days in one Policy Year.

E. EXCLUSIONS

The Company shall bear no liability to make the payment in respect of claims arising directly or indirectly out of or attributable or traceable to any of the following:

i. Standard Exclusions (Exclusions for which standard wordings are specified by IRDAI)

1. **Pre- Existing Diseases – Code –Excl01**

   a. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded as per the Plan mentioned in the Policy schedule i.e.until the expiry of 36 months or 24 months of continuous coverage after the date of inception of the first policy with Us.

   b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase.

   c. If the Insured person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to be extent of prior coverage.

   d. Coverage under the policy after the expiry of applicable months as per the Plan, for any Pre-exiting Disease is subject to the same being declared at the time of application and accepted by the Insurer.

2. **Specified disease/procedure waiting period- *Code- Excl02***

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of below mentioned months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on Portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

Sr. No	First Year (12 months) Waiting Period	Two Year (24 months) Waiting Period	Three Year (36 months) Waiting Period
1.	Cataract	Calculus diseases of Gall bladder and Urogenital system	Surgical Treatment of Obesity
2.	Benign Prostatic Hypertrophy	Joint Replacement due to Degenerative condition,	Infertility Treatment
3.	Hernia	Surgery for prolapsed inter vertebral disc unless arising from accident	
4.	Hydrocele	Age related Osteoarthritis and Osteoporosis	
5.	Fistula in anus	Spondylosis / Spondylitis	
6.	Piles	Surgery of varicose veins and varicose ulcers.	
7.	Sinusitis and related disorders	Treatment for correction of eye sight (laser surgery) due to refractive error	
8.	Fissure		
9.	Gastric and Duodenal ulcers		
10.	Gout and Rheumatism		
11.	Internal tumors, cysts, nodules, polyps , breast lumps (unless malignant)		
12.	Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus		
13.	Polycystic ovarian diseases		
14.	Skin tumors (unless malignant)		
15.	Benign ear, nose and throat (ENT) disorders and surgeries, adenoidectomy,mastoid ectomy, tonsillectomy and tympanoplasty		
16.	Dilatation and Curettage (D&C);		
17.	Congenital Internal		

	Diseases		

3. **30-day waiting period- *Code- Excl03***
   a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

   The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

4. **Investigation & Evaluation – Code-Excl04**

   a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. **Rest Cure, rehabilitation and respite care- Code- Excl05**
   a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. **Obesity/ Weight Control: Code- Excl06**
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Doctor
   2) The surgery/Procedure conducted should be supported by clinical protocols
   3) The member has to be 18 years of age or older and
   4) Body Mass Index (BMI);
      a) greater than or equal to 40 or
      b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe Sleep Apnea
         iv. Uncontrolled Type 2 Diabetes

7. **Change-of-Gender treatments: *Code- Excl07***

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

8. **Cosmetic or plastic Surgery: *Code- Excl08***
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

9. **Breach of law: *Code- Excl 10***
   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

10. **Excluded Providers : Code-Excl11**
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

11. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

12. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code - Excl 13**

13. Dietary supplements and substances that can be purchased without prescription including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code-Excl 14**

14. **Unproven Treatments**: ***Code- Excl16***
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

ii. Specific Exclusions (Exclusions other than those mentioned under E(i) above)

1. 90 days Waiting Period Exclusion**:** A waiting period of 90 days from the commencement date of the first Policy will apply to Critical Illness (es) contracted requiring Hospitalization

2. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice & Trichomoniasis, Human T Cell Lymphotropic Virus Type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

3. Any dental treatment or surgery unless requiring hospitalization arising out of an accident.

4. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

5. Charges incurred in connection with cost of spectacles and contactlenses, hearing aids, routine eye and ear examinations, dentures, artificial teeth and all other similar external appliances and /or devices whether for diagnosis or treatment.

6. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.P.A.D) and oxygen concentrator or asthmatic condition, cost of cochlear implants.

7. External Congenital Anomaly.

8. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident

9. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy.

10. Treatment received outside India unless specifically mentioned in your policy schedule.

11. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, mutiny, military or usurped acts, seizure, capture, arrest, restraints and detainment of all kinds.

12. Act of self-destruction or self-inflicted, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens.

13. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.

14. Personal comfort and convenience items or services, TV(wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs, (except patient's diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

15. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
    a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of

fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and /or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death

In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded.

16. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products.

17. Drugs or treatment and medical supplies not supported by a prescription from a Medical Practitioner.

A. Special Exclusions applicable to Optional Cover ' Personal Accident Cover' Section 2. Of Part III. Of the Policy cover –

In addition the General Exclusions listed above the Policy shall not cover following unless expressly stated to the contrary elsewhere in this Policy:

1. Any claim in respect of accidental death or accidental injury caused by curative measures, radiation, infection, poisoning except where these arise from an accident.

2. In the event the Insured Person is a victim of culpable homicide, i.e. where he dies due to act committed against him, which act is committed with the intention of causing death or with the intention of causing accidental injury as is likely to cause death, or with the knowledge that such act is likely to cause death.

3. driving any vehicle without a valid driving licence

4. whilst engaging as a driver, co-driver or passenger of a vehicle engaging in speed contest or racing of any kind or participating in a trail run.

F. GENERAL TERMS AND CONDITIONS

i. Standard General Terms and Clauses (General terms and clauses whose wordings are specified by IRDAI)

a. Disclosure of information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

("Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

b. Condition Precedent to admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

c. Claim Settlement (Provision for Penal Interest)

a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
d. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Explanation: "Bank Rate" shall mean the rate fixed by Reserve Bank of Indian (RBI) at the beginning of the financial year in which the claim has fallen due.

d. Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

e. Multiple Policies

a) Indemnity based policies : In case of multiple policies held by Insured person, insured person has a choice to file claim settlement under any policy. if insured person chooses to file such claim under policy held with with the Company, then same shall be treated as the primary Insurer. In case the available coverage under the said policy is less than the admissible claim amount, then we, Liberty General Insurance as primary Insurer shall seek the details of other available policies of the Insured and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the Insured.

b) Benefit based Policies:

On occurrence of the insured event, the policyholders can claim from all Insurers under all policies.

Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used

by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

f. Cancellation/Termination

(i) The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall
a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.
(ii) The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Cancellation Grid	Time period	Claim Status	One Year -Single payment /Instalment policy	2 Years Policy tenure -Single payment /Instalment policy
Free Look Period (Risk not commenced)	Upto30 days	Nil	Full refund less medical examination of insured person and the stamp duty charges	
Free Look Period (Risk commenced)	Upto30 days	Nil	Proportionate refund for unexpired policy period	

Pro rate (Risk commenced)	Beyond 30 days	Nil	Proportionate refund for unexpired policy period

In the event of the death of the Insured Person/s during the currency of the Policy, due to any reason and subject to there being no claim reported under the Policy, the Policy would cease to operate and the nominee/legal heir would be entitled to a refund in premium from the date of death to the expiry of policy and such refund would be governed by the provisions relating to the Cancellation by Insured / Insured Person/s as specified above. In case of a family floater, upon the death of the Policy holder, this Policy shall continue till the end of the Policy Period. If the other Insured Person/s wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of an Insured.

g. Migration

"Migration" means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per the IRDA Guidelines on Migration. If such person is presently covered and has been continuously covered without any lapse under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDA Guidelines on Migration.

h. Portability

"Portability" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. lf such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an lndian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

i. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person.

i. The Company shall give notice for renewal atleast 30 days prior to expiry of the policy
ii. Renewal of a health insurance policy shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

j. Withdrawal of Policy

In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

k. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

Note :The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

m. Premium Payments in Installments

If the insured person has opted for payment of premium on an installment basis i.e. Half Yearly, Quarterly or Monthly as mentioned in the certificate of insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy). This facility needs to be opted before inception of the policy and opting ECS/SI payment mode.

i. The grace period of fifteen days (where premium is paid in monthly installments) and thirty days (where premium is paid in quarterly/half-yearly/annual installments) is available on the premium due date, is available to the policyholder to pay the premium.

ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

iii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Given below are the payment terms applicable on standard premiums in case of installments.

Installment Frequency	% of Annual Premium
Half Yearly	51%

Quarterly	26%
Monthly	8.75%

n. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

Insured Person/s could avail of policy renewal in terms of the applicable portability norms governing such renewals and the same would be renewed in accordance with the Company's Board approved underwriting policy.

The table below illustrates the waiting period which would be applicable as per Portability norms:

		Waiting period to be served with new insurer in number of days/years upon Portability		
Sl No	No of years of continuous insurance cover with previous insurer(s)	30 days waiting period	2 years waiting period	3 year waiting period for PED
1	1 Year	NIL	1 Year	2 Years
2	2 years	NIL	NIL	1 Year
3	3 years	NIL	NIL	NIL

o. Free Look Period

The insured person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. The Free Look Period shall be applicable only for new individual health insurance policies, except for those policies with tenure of less than a year and not on renewals.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to -

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

p. Redressal of Grievance

In case of any grievance the insured person may contact the company through

Step 1	Step 2
Call us on Toll free number: **1800-266-5844** (8:00 AM to 8:00 PM, 7 days of the week) or **Email us at**: care@libertyinsurance.in **Senior Citizens can email us at**: seniorcitizen@libertyinsurance.in or	If our response or resolution does not meet your expectations, you can escalate at Manager@libertyinsurance.in **Step 3** If you are still not satisfied with the resolution provided, you can further

Write to us at: **Customer Service** **Liberty General Insurance Limited** Address:	escalate at ServiceHead@libertyinsurance.in

Insured person may also approach the grievance cell at any time of the Company's branches with the details of the grievance.
If the insured person is not satisfied with the redressal of the grievance through one of the above methods, insured person may contact the grievance officer at gro@libertyinsurance.in.
For updated details of grievance officer kindly refer https://www.libertyinsurance.in/customer-support/grievance-redressal
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided in **Annexure B**:

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

The updated grievances redressal procedure shall be provided on the website of the Company and is subject to change in compliance with guidelines/regulations issued by Insurance Regulatory and Development Authority of India.

q. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. ln the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

ii. Specific terms and clauses (terms and clauses other than those mentioned under F(i) above

a. **Observance of Terms and Conditions**

The due observance and fulfillment of the terms, conditions and endorsements, including the payment of premium of this Policy and compliance with specified claims procedure insofar as they relate to anything to be done or complied with by the Insured shall be a Condition Precedent to any liability of the Company to make any payment under this Policy.

b. Alterations to the Policy

This Policy together with the Policy Schedule constitutes the complete contract of insurance. This Policy cannot be changed or varied by any one (including an insurance agent or broker) except the Company, and any change We make will be evidenced by a written endorsement signed and stamped by the Company.

c. Material Change

It is a Condition Precedent to the Company's liability under the Policy that the Insured Person/s shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his/ their own expense. The Company may adjust the scope of cover and/or the premium paid or payable as per the board approved underwriting policy of the Company.

d. Records to be maintained

The Insured Person/s shall keep an accurate record containing all relevant medical documents including a variety of types of "notes" entered over time by Medical Practitioner, recording observations and administration of drugs and therapies, Investigation reports and shall allow the Company to inspect such record. The Insured Person/s shall furnish such information to the Company as may be required under this Policy, during the Policy Period or until the final adjustment, if any, and resolution of Claim/s under this Policy whichever is later.

e. Notice of charge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, or other dealing with or relating to this Policy, but the payment by the Company to the Insured Person/s, his/her nominees or legal representatives, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

f. Area of Validity

The policy shall provide for eligible medical treatment taken within India and World-wide (as applicable and specified in the Policy) & all the benefits under the policy shall be payable in Indian rupees only.

g. **Policy Disputes**

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to, by both the Insured and the Company to be subject to Indian law. Each party agrees to be subject to the executive jurisdiction of the High Court of Mumbai and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

h. **Arbitration**

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no dispute or difference shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a Condition Precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

i. Notice

Every notice and communication to the Company required by this Policy shall be in writing, within specified time and be addressed to the nearest office of the Company.

j. Electronic Transaction

The Insured agrees to adhere to and comply with all such terms, conditions and exclusions as the Company may prescribe from time to time, and hereby agrees and validates that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, has his concurrence and full understanding of the terms and conditions affecting this Contract and shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure adherence to conditions of section 41 of the Insurance Act 1938 with full disclosures on terms, conditions and exclusions. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and sent to the Insured Person, duly validated/confirmed by the Insured Person.

G. OTHER TERMS AND CONDITIONS:

1. **Entry Age**

   Minimum entry Age: Adult –18 years; Child -91 days
   Maximum entry Age: 65 Years

2. **Dependent child/children:** covered with Us under Family Floater shall have the option to continue renewal by migrating to a suitable policy at the end of the specified exit age. Due credit for continuity in respect of the previous policy period will be allowed provided the earlier policies have been maintained without a break.
3. **Sub -standard Risk**

   Proposals where the Health status is adverse, as revealed in the proposal form or as evidenced in the pre policy check-up may be accepted as per the board approved underwriting policy of the Company with an increased risk rating which shall not exceed 100% of normal slab premium per diagnosis / medical condition and not over 200% of normal slab premium per person. Applicable for all subsequent renewal(s) involving age slab changes and increase in Basic Sum Insured.

   If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing, then Pre-Existing Condition Exclusion (Part E.1) shall be applicable.

In all such cases, we would send a communication letter to the Proposer and obtain his/her consent before acceptance of the Proposal.

4. **Discount Parameters**

1. Family Discount: A Family discount of 10% will be given if more than 2 family members are covered on Individual Sum Insured basis
2. Multi-year Policy Discount: A discount of 7.5% will be given on selection of 2 year tenure policies.
3. Employee discount: A discount n the same policy on Individual / Family floater basis.
4. Renewal Discount- Avail 2.25% discount on Renewal Premium for claim free renewal in the lieu for CB

Above discounts are available of 10% will be given if the Insured/ Insured person is an Employee on roll of the Company at start date of the Policy. Such discount is applicable to his/hers family members insured ie at the time of first policy issuance as well as on renewal of this policy with Us.

5. Claim Procedure:

a. **Notification of claim:** Upon the happening of any event giving rise or likely to give rise to a claim under this Policy, the Insured/Insured Person(s) shall give immediate notice to the TPA named in the Policy/Health Card or the Company by calling toll-free number as specified in the Policy/Health Card or in writing to the address shown in the Schedule with Particulars below:

i. Policy Number / Health Card No.
ii. Name of the Insured / Insured Person availing treatment
iii. Details of the disease/illness/injury
iv. Name and address of the Hospital
v. Any other relevant information

Intimation must be given atleast 48 hours prior to planned hospitalization and within 24 hours of hospitalization in case of emergency hospitalization. In event of any claim for Pre – Post Hospitalization expenses incurred, all claim related documents needs to be submitted within 7 days from the date of completion of treatment or eligible Post Hospitalization period as mentioned in the policy schedule whichever is earlier.
The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured Person/s. The Insured Person/s shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder. The Company shall settle claims, including its rejection, within thirty working days of receipt of the last required documents.

b. **For opting Cashless Facility**: (applicable where the Insured Person/s has opted for cashless facility in a Network Hospital) - The Insured Person must call the helpline and furnish membership Number and Policy Number and take an eligibility number to confirm communication. The same has to be quoted in the claim form. The call must be made 48 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 24 hours of admission.

i. The company may provide Cashless facility for Hospitalisation expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorisation letter to the health care service provider.
ii. For the purpose of considering Pre-Authorisation and Cashless facility, the Insured Person/s shall submit to the TPA complete information of the disease, requiring treatment along with necessary certification from the Hospital/Medical Practitioner.
iii. If the claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorisation to the Hospital concerned for cashless facility whereby hospitalization expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorisation.
iv. Cashless facility will not be available in Non-network Hospital and may be declined even for treatment at a network hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such cases, the Insured Person/s shall bear such expenses and claim reimbursement immediately after discharge from the Hospital.
v. The list of Network hospitals where we are having cash less arrangement would be made available to the Policy holder and subsequent amendments to the same would also be duly communicated by us/ the TPA service provider.

c. **Reimbursement Claims** - Notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us immediately on hospitalization /injury/ death, failing which admission of claim would be based on the merits of the case at our discretion. The Insured Person/s shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 15 days of discharge from the hospital the following:

i. Claim form duly completed in all respects
ii. Original Bills, Receipt and Discharge certificate / card from the Hospital.
iii. Original Cash Memos from Hospital(s)/Chemist(s), supported by proper prescriptions.
iv. Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.
v. Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt.
vi. Attending Doctor's / Consultant's / Specialist's / - Anesthetist's original bill and receipt, and certificate regarding diagnosis.
vii. Medical Case History / Summary.
viii. Original bills & receipts for claiming Ambulance Charges
ix. Any additional documents or information, as may be deemed necessary by the Company or TPA.

The Insured Person/s shall at any time as may be required authorize and permit the TPA and/or Company to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim. The Company may call for additional documents/information and/or carry out verification on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the extent of loss. Verification carried out will

be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company.
The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured/ Insured Person/s. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

Applicable Taxes prevailing at the time of claim will be considered as part of the Claim Amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Basic Sum Insured opted.

No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy.

LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

- ***In-patient Treatment /Day Care Procedures***

1. Duly filled and signed Claim Form.
2. Photocopy of ID card / Photocopy of current year policy.
3. Original Detailed Discharge Summary / Day care summary from the hospital.
4. Original consolidated hospital bill with bill no and break up of each Item, duly signed by the insured.
5. Original payment Receipt of the hospital bill with receipt number
6. First Consultation letter and subsequent Prescriptions.
7. Original bills, original payment receipts and Reports for investigation supported by the note from Attending Medical Practitioner / Surgeon demanding such test.
8. Copy of Indoor cases papers and other medical records as applicable for claim
9. Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts
10. Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same
11. Original medicine bills and receipts with corresponding Prescriptions.
12. Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.
13. Hospital Registration Number and PAN details from the Hospital
14. Doctors registration Number and Qualification from the doctor
15. Photo ID and Address proof of policy holder and patient
16. Original cancelled cheque with payee name printed on the cheque. If the name of the payee is not printed on the cheque please provide copy of first page of bank passbook
17. C-KYC form for claims above 1 lac

- ***OPD Treatment***

1. Duly filled and signed Claim Form
2. Photocopy of ID card / Photocopy of current year policy
3. Consultation letter and subsequent Prescriptions.
4. Original bills, original payment receipts
5. In case of a Claim towards Physiotherapy, need to be supported by a prescription from the treating specialist consultant/specialist medical practitioner as a medically necessary treatment

- ***Road Traffic Accident***

In addition to the In-patient Treatment documents:

1. Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.
2. In Non Medico legal cases
3. Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)
4. In Accidental Death cases
5. Copy of Post Mortem Report (if conducted) & Death Certificate

- ***For Death Cases***

In addition to the In-patient Treatment documents:

1. Original Death Summary from the hospital.
2. Copy of the Death certificate from treating doctor or the hospital authority.
3. Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

- ***Pre and Post-hospitalization expenses***

1. Duly filled and signed Claim Form.
2. Photocopy of ID card / Photocopy of current year policy.
3. Original Medicine bills, original payment receipt with prescriptions.
4. Original Investigations bills, original payment receipt with prescriptions and report.
5. Original Consultation bills, original payment receipt with prescription.
6. Copy of the Discharge Summary of the main claim.

- ***Ambulance Benefit***

1. Duly filled and signed Claim Form.
2. Photocopy of ID card / Photocopy of current year policy.
3. Original Bill with Original Payment Receipt.
4. Treating Doctor's consultation prescription indicating Emergency Hospitalization.

- ***Reimbursement of Organ Donor Expenses***

In addition to the documents of general hospitalization

1. Organ Function test / blood test proving organ failure.
2. Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

- ***Hospital Cash Allowance***

Same as In-patient Hospitalization treatment

- ***Restoration/Reinstatement of the Sum Insured***

Same as In-patient Hospitalization treatment

- ***Nursing Allowance***

In addition to the In-patient Treatment documents:

1. Duly signed prescription for Private Nursing requirement and its necessity from the treating Medical Practitioner
2. Original Bill with Original Payment Receipt of Nursing charges from the utilized Nursing Burrow/Private Nurse

- ***Maternity benefit***

In addition to the In-patient Treatment documents:

1. ANC records of Patient
2. Obstetric history of patient

➢ ***Critical Illness Benefit***

1. Duly filled and signed claim form
2. Photocopy of current year policy
3. Copy of Discharge summary if any
4. Medical certificate for the duration of illness
5. A medical certificate confirming the diagnosis of critical illness from a doctor not qualified less than MD / MS
6. Investigation reports / other related documents reflecting the critical illness diagnosis
7. First consultation letter and subsequent prescription
8. Original cancelled cheque with payee name printed on the cheque. If the name of the payee is not printed on the cheque please provide copy of first page of bank passbook

➢ ***Personal Accident Benefit***

Death

1. Duly Completed Personal Accident Insurance Policy Claim Form signed by Nominee.
2. Copy of address proof (Ration card or electricity bill copy).
3. Attested copy of Death Certificate.
4. Burial Certificate (wherever applicable)
5. Attested copy of Statement of Witness, if any lodged with police authorities.
6. Attested copy of FIR / Panchanama / Inquest Panchanama.
7. Attested copy of Post Mortem Report (only if conducted).
8. Attested copy of Viscera report if any(Only if Post Mortem is conducted).
9. Claim form with NEFT details
10. Original cancelled cheque with payee name printed on the cheque. If the name of the payee is not printed on the cheque please provide copy of first page of bank passbook
11. Original Policy copy

Permanent Partial /Total Disablement /Temporary Total Disability

1. Duly Completed Personal Accident Insurance Policy Claim Form signed by insured.
2. Attested copy of disability certificate from Civil Surgeon of Government Hospital stating percentage of disability.
3. Attested copy of FIR.
4. All X-Ray / Investigation reports and films supporting to disablement.
5. Claim form with NEFT details
6. Original cancelled cheque with payee name printed on the cheque. If the name of the payee is not printed on the cheque please provide copy of first page of bank passbook
7. Original Policy copy.

➢ ***Extended Policy Tenure***

1. Proof of travel outside the Country specifying a period more than 15 days consecutively.

➢ **Tele-medicine**

- ❑ A proper invoice or numbered bill of consultation with date
- ❑ A proof of payment either a Online, G-PAY or Pay-TM
- ❑ The consultation note or Prescription with Physicians registration number and details
- ❑ All investigation report advised with bills and prescription

We may call for additional documents/ information as relevant to the claim.

Applicable to all claims under the Policy:

a. In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, We shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.
b. If required, the Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense.
c. If required, the Insured person must agree to be examined by a medical practitioner of our choice at Our expenses.
d. The Policy - excludes the Standard List of excluded items - attached in the Policy document.
e. All claims will be settled in accordance with relevant provisions of applicable Circulars and Regulations issued by IRDAI from time to time.
f. No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy

BENEFIT SCHEDULE: As Annexed

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LIST OF DAY CARE PROCEDURES/TREATMENTS

Day Care Procedures/Treatments include the following Day Care Surgeries & Day Care Treatments and can include other Day Care procedures or surgery or treatment undertaken by the Insured Person as an inpatient for less than 24 hours in a Hospital or standalone day care centre but not in the Outpatient department of a Hospital:

ENT

1 Stapedotomy
2 Myringoplasty(Type I Tympanoplasty)
3 Revision stapedectomy
4 Labyrinthectomy for severe Vertigo
5 Stapedectomy under GA
6 Ossiculoplasty
7 Myringotomy with Grommet Insertion
8 Tympanoplasty (Type III)
9 Stapedectomy under LA
10 Revision of the fenestration of the inner ear.
11 Tympanoplasty (Type IV)
12 Endolymphatic Sac Surgery for Meniere's Disease
13 Turbinectomy
14 Removal of Tympanic Drain under LA
15 Endoscopic Stapedectomy
16 Fenestration of the inner ear
17 Incision and drainage of perichondritis
18 Septoplasty
19 Vestibular Nerve section
20 Thyroplasty Type I
21 Pseudocyst of the Pinna - Excision
22 Incision and drainage - Haematoma Auricle
23 Tympanoplasty (Type II)
24 Keratosis removal under GA
25 Reduction of fracture of Nasal Bone
26 Excision and destruction of lingual tonsils
27 Conchoplasty
28 Thyroplasty Type II
29 Tracheostomy
30 Excision of Angioma Septum
31 Turbinoplasty
32 Incision & Drainage of Retro Pharyngeal Abscess
33 Uvulo Palato Pharyngo Plasty
34 Palatoplasty
35 Tonsillectomy without adenoidectomy
36 Adenoidectomy with Grommet insertion
37 Adenoidectomy without Grommet insertion
38 Vocal Cord lateralisation Procedure
39 Incision & Drainage of Para Pharyngeal Abscess
40 Transoral incision and drainage of a pharyngeal abscess
41 Tonsillectomy with adenoidectomy
42 Tracheoplasty

Ophthalmology

43 Incision of tear glands
44 Other operation on the tear ducts
45 Incision of diseased eyelids
46 Excision and destruction of the diseased tissue of the eyelid
47 Removal of foreign body from the lens of the eye.
48 Corrective surgery of the entropion and ectropion
49 Operations for pterygium
50 Corrective surgery of blepharoptosis
51 Removal of foreign body from conjunctiva
52 Biopsy of tear gland
53 Removal of Foreign body from cornea
54 Incision of the cornea
55 Other operations on the cornea
56 Operation on the canthus and epicanthus
57 Removal of foreign body from the orbit and the eye ball.
58 Surgery for cataract
59 Treatment of retinal lesion
60 Removal of foreign body from the posterior chamber of the eye

Oncology

61 IV Push Chemotherapy
62 HBI-Hemibody Radiotherapy
63 Infusional Targeted therapy
64 SRT-Stereotactic Arc Therapy
65 SC administration of Growth Factors
66 Continuous Infusional Chemotherapy

67 Infusional Chemotherapy
68 CCRT-Concurrent Chemo + RT
69 2D Radiotherapy
70 3D Conformal Radiotherapy
71 IGRT- Image Guided Radiotherapy
72 IMRT- Step & Shoot
73 Infusional Bisphosphonates
74 IMRT- DMLC
75 Rotational Arc Therapy
76 Tele gamma therapy
77 FSRT-Fractionated SRT
78 VMAT-Volumetric Modulated Arc Therapy
79 SBRT-Stereotactic Body Radiotherapy
80 Helical Tomotherapy
81 SRS-Stereotactic Radiosurgery
82 X-Knife SRS
83 Gammaknife SRS
84 TBI- Total Body Radiotherapy
85 intraluminal Brachytherapy
86 Electron Therapy
87 TSET-Total Electron Skin Therapy
88 Extracorporeal Irradiation of Blood Products
89 Telecobalt Therapy
90 Telecesium Therapy
91 External mould Brachytherapy
92 Interstitial Brachytherapy
93 Intracavity Brachytherapy
94 3D Brachytherapy
95 Implant Brachytherapy
96 Intravesical Brachytherapy
97 Adjuvant Radiotherapy
98 Afterloading Catheter Brachytherapy
99 Conditioning Radiothearpy for BMT
100 Extracorporeal Irradiation to the Homologous Bone grafts
101 Radical chemotherapy
102 Neoadjuvant radiotherapy
103 LDR Brachytherapy
104 Palliative Radiotherapy
105 Radical Radiotherapy
106 Palliative chemotherapy
107 Template Brachytherapy
108 Neoadjuvant chemotherapy
109 Adjuvant chemotherapy
110 Induction chemotherapy
111 Consolidation chemotherapy
112 Maintenance chemotherapy
113 HDR Brachytherapy

Plastic Surgery
114 Construction skin pedicle flap
115 Gluteal pressure ulcer-Excision
116 Muscle-skin graft, leg
117 Removal of bone for graft
118 Muscle-skin graft duct fistula
119 Removal cartilage graft
120 Myocutaneous flap
121 Fibro myocutaneous flap
122 Breast reconstruction surgery after mastectomy
123 Sling operation for facial palsy
124 Split Skin Grafting under RA
125 Wolfe skin graft
126 Plastic surgery to the floor of the mouth under GA

Urology
127 AV fistula - wrist
128 URSL with stenting
129 URSL with lithotripsy
130 Cystoscopic Litholapaxy
131 ESWL
132 Haemodialysis
133 Bladder Neck Incision
134 Cystoscopy & Biopsy
135 Cystoscopy and removal of polyp
136 Suprapubic cystostomy
137 percutaneous nephrostomy
139 Cystoscopy and "SLING" procedure.
140 TUNA- prostate
141 Excision of urethral diverticulum
142 Removal of urethral Stone
143 Excision of urethral prolapse
144 Mega-ureter reconstruction
145 Kidney renoscopy and biopsy
146 Ureter endoscopy and treatment
147 Vesico ureteric reflux correction
148 Surgery for pelvi ureteric junction obstruction
149 Anderson hynes operation
150 Kidney endoscopy and biopsy
151 Paraphimosis surgery
152 injury prepuce- circumcision
153 Frenular tear repair

154 Meatotomy for meatal stenosis
155 surgery for fournier's gangrene scrotum
156 surgery filarial scrotum
157 surgery for watering can perineum
158 Repair of penile torsion
159 Drainage of prostate abscess
160 Orchiectomy
161 Cystoscopy and removal of FB

Neurology
162 Facial nerve physiotherapy
163 Nerve biopsy
164 Muscle biopsy
165 Epidural steroid injection
166 Glycerol rhizotomy
167 Spinal cord stimulation
168 Motor cortex stimulation
169 Stereotactic Radiosurgery
170 Percutaneous Cordotomy
171 Intrathecal Baclofen therapy
172 Entrapment neuropathy Release
173 Diagnostic cerebral angiography
174 VP shunt
175 Ventriculoatrial shunt

Thoracic surgery
176 Thoracoscopy and Lung Biopsy
177 Excision of cervical sympathetic Chain Thoracoscopic
178 Laser Ablation of Barrett's oesophagus
179 Pleurodesis
180 Thoracoscopy and pleural biopsy
181 EBUS + Biopsy
182 Thoracoscopy ligation thoracic duct
183 Thoracoscopy assisted empyaema drainage

Gastroenterology
184 Pancreatic pseudocyst EUS & drainage
185 RF ablation for barrett's Oesophagus
186 ERCP and papillotomy
187 Esophagoscope and sclerosant injection
188 EUS + submucosal resection
189 Construction of gastrostomy tube
190 EUS + aspiration pancreatic cyst
191 Small bowel endoscopy (therapeutic)
192 Colonoscopy ,lesion removal
193 ERCP
194 Colonscopy stenting of stricture
195 Percutaneous Endoscopic Gastrostomy
196 EUS and pancreatic pseudo cyst drainage
197 ERCP and choledochoscopy
198 Proctosigmoidoscopy volvulus detorsion
199 ERCP and sphincterotomy
200 Esophageal stent placement
201 ERCP + placement of biliary stents
202 Sigmoidoscopy w / stent
203 EUS + coeliac node biopsy

General Surgery
204 infected keloid excision
205 Incision of a pilonidal sinus / abscess
206 Axillary lymphadenectomy
207 Wound debridement and Cover
208 Abscess-Decompression
209 Cervical lymphadenectomy
210 infected sebaceous cyst
211 Inguinal lymphadenectomy
212 Incision and drainage of Abscess
213 Suturing of lacerations
214 Scalp Suturing
215 infected lipoma excision
216 Maximal anal dilatation
217 Piles
A)Injection Sclerotherapy
B)Piles banding
218 liver Abscess- catheter drainage
219 Fissure in Ano- fissurectomy
220 Fibroadenoma breast excision
221 Oesophageal varices Sclerotherapy
222 ERCP - pancreatic duct stone removal
223 Perianal abscess I&D
225 Fissure in ano sphincterotomy
226 UGI scopy and Polypectomy oesophagus
227 Breast abscess I& D
228 Feeding Gastrostomy
229 Oesophagoscopy and biopsy of growth oesophagus
230 UGI scopy and injection of adrenaline, sclerosants
- bleeding ulcers
231 ERCP - Bile duct stone removal
232 Ileostomy closure
233 Colonoscopy
234 Polypectomy colon

235 Splenic abscesses Laparoscopic Drainage
236 UGI SCOPY and Polypectomy stomach
237 Rigid Oesophagoscopy for FB removal
238 Feeding Jejunostomy
239 Colostomy
240 Ileostomy
241 colostomy closure
242 Submandibular salivary duct stone removal
243 Pneumatic reduction of intussusception
244 Varicose veins legs - Injection sclerotherapy
245 Rigid Oesophagoscopy for Plummer vinson syndrome
246 Pancreatic Pseudocysts Endoscopic Drainage
247 ZADEK's Nail bed excision
248 Subcutaneous mastectomy
249 Excision of Ranula under GA
250 Rigid Oesophagoscopy for dilation of benign Strictures
251 Eversion of Sac
a) Unilateral
b)Bilateral
252 Lord's plication
253 Jaboulay's Procedure
254 Scrotoplasty
255 Surgical treatment of varicocele
256 Epididymectomy
257 Circumcision for Trauma
258 Meatoplasty
259 Intersphincteric abscess incision and drainage
260 Psoas Abscess Incision and Drainage
261 Thyroid abscess Incision and Drainage
262 TIPS procedure for portal hypertension
263 Esophageal Growth stent
264 PAIR Procedure of Hydatid Cyst liver
265 Tru cut liver biopsy
266 Photodynamic therapy or esophageal tumour and Lung tumour
267 Excision of Cervical RIB
268 laparoscopic reduction of intussusception
269 Microdochectomy breast
270 Surgery for fracture Penis
271 Sentinel node biopsy
272 Parastomal hernia
273 Revision colostomy
274 Prolapsed colostomy- Correction
275 Testicular biopsy
276 laparoscopic cardiomyotomy(Hellers)
277 Sentinel node biopsy malignant melanoma
278 laparoscopic pyloromyotomy(Ramstedt)

Orthopedics

279 Arthroscopic Repair of ACL tear knee
280 Closed reduction of minor Fractures
281 Arthroscopic repair of PCL tear knee
282 Tendon shortening
283 Arthroscopic Meniscectomy - Knee
284 Treatment of clavicle dislocation
285 Arthroscopic meniscus repair
286 Haemarthrosis knee- lavage
287 Abscess knee joint drainage
288 Carpal tunnel release
289 Closed reduction of minor dislocation
290 Repair of knee cap tendon
291 ORIF with K wire fixation- small bones
292 Release of midfoot joint
293 ORIF with plating- Small long bones
294 Implant removal minor
295 K wire removal
296 POP application
297 Closed reduction and external fixation
298 Arthrotomy Hip joint
299 Syme's amputation
300 Arthroplasty
301 Partial removal of rib
302 Treatment of sesamoid bone fracture
303 Shoulder arthroscopy / surgery
304 Elbow arthroscopy
305 Amputation of metacarpal bone
306 Release of thumb contracture
307 Incision of foot fascia
308 calcaneum spur hydrocort injection
309 Ganglion wrist hyalase injection
310 Partial removal of metatarsal
311 Repair / graft of foot tendon
312 Revision/Removal of Knee cap
313 Amputation follow-up surgery
314 Exploration of ankle joint
315 Remove/graft leg bone lesion
316 Repair/graft achilles tendon
317 Remove of tissue expander
318 Biopsy elbow joint lining
319 Removal of wrist prosthesis

320 Biopsy finger joint lining
321 Tendon lengthening
322 Treatment of shoulder dislocation
323 Lengthening of hand tendon
324 Removal of elbow bursa
325 Fixation of knee joint
326 Treatment of foot dislocation
327 Surgery of bunion
328 intra articular steroid injection
329 Tendon transfer procedure
330 Removal of knee cap bursa
331 Treatment of fracture of ulna
332 Treatment of scapula fracture
333 Removal of tumor of arm/ elbow under RA/GA
334 Repair of ruptured tendon
335 Decompress forearm space
336 Revision of neck muscle(Torticollis release)
337 Lengthening of thigh tendons
338 Treatment fracture of radius & ulna
339 Repair of knee joint

Paediatric surgery

340 Excision Juvenile polyps rectum
341 Vaginoplasty
342 Dilatation of accidental caustic stricture oesophageal
343 Presacral Teratomas Excision
344 Removal of vesical stone
345 Excision Sigmoid Polyp
346 Sternomastoid Tenotomy
347 Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
348 Excision of soft tissue rhabdomyosarcoma
349 Mediastinal lymph node biopsy
350 High Orchidectomy for testis tumours
351 Excision of cervical teratoma
352 Rectal-Myomectomy
353 Rectal prolapse (Delorme's procedure)
354 Orchidopexy for undescended testis
355 Detorsion of torsion Testis
356 lap.Abdominal exploration in cryptorchidism
357 EUA + biopsy multiple fistula in ano
358 Cystic hygroma - Injection treatment
359 Excision of fistula-in-ano

Gynaecology

360 Hysteroscopic removal of myoma
361 D&C
362 Hysteroscopic resection of septum
363 thermal Cauterisation of Cervix
364 MIRENA insertion
365 Hysteroscopic adhesiolysis
366 LEEP
367 Cryocauterisation of Cervix
368 Polypectomy Endometrium
369 Hysteroscopic resection of fibroid
370 LLETZ
371 Conization
372 polypectomy cervix
373 Hysteroscopic resection of endometrial polyp
374 Vulval wart excision
375 Laparoscopic paraovarian cyst excision
376 uterine artery embolization
377 Bartholin Cyst excision
378 Laparoscopic cystectomy
379 Hymenectomy(imperforate Hymen)
380 Endometrial ablation
381 vaginal wall cyst excision
382 Vulval cyst Excision
383 Laparoscopic paratubal cyst excision
384 Repair of vagina (vaginal atresia)
385 Hysteroscopy, removal of myoma
386 TURBT
387 Ureterocoele repair - congenital internal
388 Vaginal mesh For POP
389 Laparoscopic Myomectomy
390 Surgery for SUI
391 Repair recto- vagina fistula
392 Pelvic floor repair (excluding Fistula repair)
393 URS + LL
394 Laparoscopic oophorectomy

Critical care

395 Insert non- tunnel CV cath
396 Insert PICC cath (peripherally inserted central catheter)
397 Replace PICC cath (peripherally inserted central catheter)
398 Insertion catheter, intra anterior
399 Insertion of Portacath

Dental

400 Splinting of avulsed teeth
401 Suturing lacerated lip
402 Suturing oral mucosa
403 Oral biopsy in case of abnormal tissue presentation
404 FNAC
405 Smear from oral cavity

Note: The standard exclusions and waiting periods are applicable to all of the above Day Care Procedures depending on the medical condition

Annexure-A

List I – Items for which coverage is not available in the policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES

35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES

30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET

23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

Sl No	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES-DIET CHARGES (*Payable incase medically advisable for the treatment)
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION⁄STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure-B

The contact details of the **Insurance Ombudsman** offices are as below-

Areas of Jurisdiction	**Office of the Insurance Ombudsman**
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in

Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.l.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor,

	4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur,

	Patna 800 006. Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in